Small Business Health Options Program (SHOP) Public Comments

Virginia Mainstreet Alliance

Best Value Consulting (Health Savings Accounts)

United Concordia Dental

COMMENTS FROM THE VIRGINIA MAIN STREET ALLIANCE

FOCUSED ON SMALL BUSINESS HEALTH OPTIONS EXCHANGE

First, we want to thank you for the opportunity to comment. The VHRI has done a great job of soliciting and respecting public comments from a very divers set of people on this issue.

We also want to thank each VHRI member for working together so hard and with such open minds as you have striven to make the best recommendation possible. You have done a great job and a great service for Virginia.

The challenge now is turning your wonderful recommendations into a wonderful reality for the people of the Commonwealth. While our comments will focus on the SHOP we want to be a little broader because, as small businesses, we have a huge interest in health care reform working for Virginia.

In that vein, our first suggestion is that the VHRI "keep on keeping on." We see a role for an oversight body like the VHRI in keeping Virginia on the right track on health care reform. We further suggest that VHRI take a little time at every meeting to review progress on the 2010 report, reviewing the broader outlines of health care reform and making sure that Virginia is moving forward on all the recommendations the VHRI made.

Specifically on the Small Business Health Options Exchange, we will suggest that the VHRI focus on the tens of thousands of Virginia's small businesses with ten or fewer employees. These small businesses pay 18% more than large businesses for the same premiums. Small businesses such as these have no HR department so every moment dealing with the bureaucracy is a moment stolen from the business and every extra dollar in premiums is a dollar taken from someone's pocket.

To this end we recommend:

1) Reviewing the decisions to require 2 employees before a small business can benefit from the SHOP and the prohibition on using the SHOP's buying power to generate better rates for small businesses. We know from the discussion on where to house the exchange at the May 24 meeting that the VHRI believes in the decisions it has made and wants the state to adopt them, but changing your recommendation on these two will significantly help small businesses.

2) Simple Choices for Owners. The website for the SHOP should lay out choices that overworked small business owners can easily understand. The ranking of plans into platinum, gold, silver and bronze categories will help, but the same philosophy needs to go deeper. The website should group similar plans together, clearly noting their similarities and differences so that small businesspeople can easily decide what is right for them.

3) Real Choices for Employees and Employers. One advantage larger businesses have is employee choice. The SHOP should allow small businesses to "buy in," setting a level of support and then letting their employees choose from several plans to find the one that best fits the employee's needs. Small businesses need a single bill to the employer and an easy way for employees to pay for the extra benefits they choose.

4) Real Outreach to Small Businesses. To ensure that small businesses use and benefit from the SHOP VHRI should recommend a special outreach program to effectively reach the hundreds of thousands of small businesses that may benefit from the SHOP.

Thank you again for your time and effort.

Bob Becker
State Coordinator, Virginia Main Street Alliance

Health Savings Accounts

Dear Madame Director and Committee Members,

Please consider the Health Savings Account (HSA) utilization from the system integration perspective of data sharing with the IRS for subsidy. Please also consider HSA integration with SHOP Essential Health Plan and other carriers health plans by integrating system funcitionality with 3rd party HSA Administrators. Let's not lose sight of the power of the HSA to make patients consumers focused on their utization of health care rather than the co pay for an office visit and RX fill and monthy payment. Thanks for all you do,Best to you all. Rich Nagel

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UNITED CONCORDIA®
Insuring America's Dental Health

June 7, 2012

The Honorable William A. Hazel, Jr., M.D.
Secretary of Health and Human Resources
Commonwealth of Virginia
1111 East Broad Street, Suite 4001
Richmond, VA 23219-1922

Submitted electronically via: VHRI@governor.virginia.gov

Re: Essential Health Benefits

Dear Secretary Hazel:

United Concordia Dental appreciates the opportunity to submit comments on "Essential Health Benefits" for products that will be offered both on and off Virginia's AHBE and SHOP exchanges.

United Concordia Dental is a leading national dental carrier that delivers high-quality cost-effective dental programs focused on improving oral health to 6 million members nationwide including more than 195,000 Virginians. Our primary mission is to help improve the oral health of not only our members, but also the communities within which we live and work. Through collaboration with local organizations, groups and individuals, we reach out to our communities to help those in need access dental health care.

The Patient Protection and Affordable Care Act (ACA) expressly allows stand-alone dental plans to be offered in the individual and SHOP exchanges if they provide the pediatric oral services required as part of the Essential Health Benefit Package (EHB). These dental plans may be offered either independently or together with QHPs that cover the balance of the EHB (*ACA Section 1311(d)(2)(B)(ii); 45 CFR 155.1065(b)*). An exchange must permit both options.[1]

While the *Essential Health Benefits Bulletin* and *Frequently Asked Questions Essential Health Benefit Bulletin* (released December 16, 2011 and February 17, 2012 respectively) point toward future guidance, United Concordia Dental supports the VHRI's efforts to develop recommendations for the General Assembly. To this end, United Concordia Dental recommends the following:

- **Select a pediatric dental benchmark that balances affordability and coverage: any of the largest three by enrollment commercial small group dental programs.** The design and cost of pediatric oral services have broad implications for continuity of coverage for those Virginians (both children and adults) who currently have public or private dental coverage, and access for children who do not currently have coverage. A *dental-specific* small employer plan as a benchmark for pediatric dental provides greater flexibility than "filling

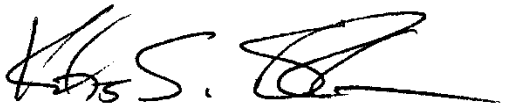
in" the missing pediatric oral services using the Federal Employees Dental & Vision Program (FEDVIP) or CHIP benchmarks.

- **Establish a minimum actuarial value of 80% (gold) for pediatric dental benefits offered through an Exchange, whether by a stand-alone dental plan or a QHP.** The actuarial value of a typical children's dental plan will be in the gold or platinum level. Reducing the actuarial value of the pediatric dental benefits to the silver level would require increasing the patient cost-sharing above 50% for some benefits, making them "illusory."

- **Virginians with dental coverage should not be required to purchase duplicative coverage.** A goal of the ACA is to expand access for those not covered while allowing the continuity of coverage and care for those who have coverage today. When small employers bring their employees to Exchanges for medical coverage, the stand-alone dental benefits they provide for their employees outside the Exchange should be accepted if they meet Virginia's benchmark established for pediatric dental. In addition there will be instances when children with two parents or guardians will have dental coverage through the parent or guardian working for a large employer. In this instance, the parent or guardian working for a small employer should not be required to purchase duplicative dental coverage for the children.

The enclosed document addresses each of these statements in further detail. Thank you for consideration of our suggestions. Should you or the VHRI Advisory Council have any questions about our comments, please feel free to contact me at 717-260-6983 or kurtis.shook@ucci.com.

Sincerely,



Kurtis S. Shook
Director, Health Care Reform Exchanges
United Concordia Dental

Enclosure

[1] *See HHS discussion of 45 CFR 155.1065(b) in Analysis and Responses to Public Comments published with Final Rule on the Establishment of Exchanges and Qualified Health Plans, pg 18411 of Federal Register, Vol. 77, No. 59, March 27, 2012*

Attachmen

EHB Dental Benchmarks

United Concordia Dental appreciates the opportunity to submit comments on "Essential Health Benefits" for products that will be offered both on and off Virginia's AHBE and SHOP exchanges.

In the December 16, 2011 *Essential Health Benefits Bulletin* HHS outlined four health benefit benchmarks including policies from small employers, state employees, the Federal Employees Health Benefits Program (FEHBP) and non-Medicaid HMOs. HHS also included two benchmarks for dental when pediatric dental is "missing" from these health-specific benchmarks. The dental benchmarks include the Federal Employees Dental & Vision Program (FEDVIP) and the state's Children's Health Insurance Plan (CHIP). In addition, HHS noted that it intends to propose "medically necessary" orthodontia as part of the EHB package.

Of the four health options, FEHBP is the only benchmark that includes pediatric dental coverage. Both the Blue Cross Blue Shield FEHB Basic and Standard plans include preventive and restorative dental procedures. However, the higher cost sharing results in patients receiving less value than typical dental coverage[i]. The two dental-specific benchmarks, FEDVIP and CHIP cover similar services; however, FEDVIP was designed with federal employees (adults) in mind and CHIP has no consumer cost sharing. Neither benchmark parallels typical private market dental plans. HHS has not specifically included a benchmark that reflects pediatric dental in a typical employer policy per ACA §1302(b)(2)(A).

With the inclusion of the dental specific benchmarks, HHS implies that "pediatric oral services" are tied to typical dental plans. However, since the benchmarks that are used are atypical, United Concordia Dental recommends that the Commonwealth consider any of the three largest small employer *dental* plans as a benchmark for pediatric dental just as the default for health coverage is largest medical plan by enrollment in the State's small group market.

Select a Pediatric Dental Benchmark that Balances Affordability and Coverage

HHS noted in the *Essential Health Benefits Bulletin* that it "sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input to date." United Concordia Dental agrees with the importance of balancing these goals to assure that a range of high-quality, affordable health and dental coverage choices is available to consumers in a competitive market. *United Concordia Dental recommends selection of any one of the three largest (by enrollment) small group dental plans.*

The design and cost of pediatric oral services have broad implications for continuity of coverage for those Virginians (both children and adults) who currently have public or private dental coverage, and access for children who do not currently have coverage. Through 2008, 57% of the U.S. population had dental coverage—a percentage that had been relatively stable for several years. Although nationwide enrollment declined in 2009, largely a result of the economy, it rebounded in 2010 to 57%. (Note: during this period both new and in-force premiums rose only by 1% to 4% depending on the type of product.) National Association of Dental Plans (NADP) consumer survey data confirm there is high consumer price sensitivity to premium increases for dental coverage.[ii]

It is essential that the children's EHB package not be so costly as to deter families from selecting dental coverage. Affordable access to preventive dental services and early diagnosis necessary to reduce dental disease and expensive treatment is, after all, one of reasons that dental coverage was deemed to be an essential health benefit in the Affordable Care Act.

So how much do dental plans cost? The NADP commissioned Milliman (an independent actuarial and benefit firm) to estimate monthly premium costs for the pediatric dental benchmarks outlined in HHS guidance. The estimates assume no annual or lifetime limits, no deductible on class I (diagnostic & preventive) services, coverage of child related services for ages up to 21, and national average costs. To date, HHS has not defined "medical necessity" for orthodontia, and States vary widely in their parameters for orthodontia in public programs. As such, the illustrative costs for "medically necessary" orthodontia are shown as a range. The most restrictive definition provides coverage only for treatment of cleft palate, a mid-range Salzmann score (e.g., a 42 which is used in California and Illinois; 40 in Oregon) provides coverage for treatment of severe or handicapping malocclusion and low threshold (e.g., Salzmann score of 25, which is the current Pennsylvania index for CHIP) allows treatment whenever indicated by a dentist. United Concordia Dental's opinion is that a Salzmann index should be **at least** 32-35 otherwise utilization of orthodontic services will be high and the premium will be relatively unaffordable for those consumers who purchase coverage on the Exchange. Currently under *Smiles for Children,* Virginia's Medicaid/ FAMIS/FAMIS Plus dental program, a patient must meet minimum Salzmann index of 25 or medical criteria and have prior approval. The cost increases shown below for the pediatric dental benchmark selected by Virginia could be higher or lower depending on the definition that is used for medical necessity.

2014 Illustrative Premiums per Child up to Age 21 in Addition to Medical[iii]

Benchmark	Description	Without Ortho		With Midlevel MN Ortho	
		Per Child Per Month	Per Child Per Year	Per Child Per Month	Per Child Per Year
Typical Small Employer Dental Plan (not currently allowed as benchmark)	**Common Small Employer DPPO without Ortho** $1,000 Annual Maximum; In Network: 100/80/50 with $50 deductible; Out-of-network: 80/60/40 with $50 deductible on class I & II services [iv]	$21.00	$252	$23.80	$285.60
FEHBP Plan with Largest Enrollment (BCBS Standard)	**Schedule of Covered Dental Procedures** including Diagnosis/Prevention/Emergency/Restorative & Extractions with scheduled payment based on age. Any services not listed are non-covered benefits**.**	$4.50	$54	$7.30	$87.60
FEDVIP Dental with Largest Enrollment (MetLife)	**DPPO** no Annual Maximum[v]; 100/70/50 in-network & 90/60/40 out of network with $50 deductible. *(NOT INCLUDED—The MetLife plan includes 50% coinsurance on ortho up to age 19 with a 24 month waiting period and $3500 lifetime limit. To add ortho to this cost, see ortho 50/50 add-on below.)*	$24.50	$294	$27.30	$327.60
State CHIP Program	**CHIP Equivalent** [vi] no annual maximums or cost-sharing	$29.25	$351	$32.05	$384.60
Medically Necessary (MN) Orthodontia	**Ortho @ 50% coinsurance**[vii] *(cost depends on the definition of "medical necessity*[viii]*")*	$0.40 - $9.40	$4.80 - $112.80		
	Ortho with 100% coverage[ix] *(cost depends on the definition of "medical necessity with no coinsurance)*	$0.80 - $18.75	$9.60 - $225		

The ACA requirement of pediatric dental within the EHB changes the dynamic of coverage. Currently, employers offer dental benefits to their employees with the election to have their families covered. In 2014, the policy will be issued for the child with the adults as additional coverage. Therefore if the cost of the children's coverage is excessive, parents/guardians may not continue dental coverage for themselves. Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today would drop coverage if their dental coverage is separated from their children's coverage and the cost of the children's coverage is substantial.[x]

With the Surgeon General's finding that dental coverage results in more dental visits by both adults and children and the more recent linkages of oral and overall health, any degradation of dental coverage will have an overall negative impact on oral health, overall health and the cost of health coverage. A recent landmark study, conducted by Professor and Dean Emeritus Marjorie Jeffcoat, D.M.D., of the University of Pennsylvania, School of Dental Medicine, in partnership with United Concordia Dental and Highmark, looked at medical and dental claims data of people with Type II diabetes from a pool of 1.7 million individuals. The research found, based on three years of study data, that each diabetic member who treated their gum disease:

- Saved an average of $1,814 in medical costs annually
- Had an average reduction of 33% in annual hospital admissions
- Had an annual average of 13% fewer physician visits

Therefore, allowing families to stay together while providing high quality dental policy options with affordable costs is critical.

Establish a Minimum Actuarial Value of 80% for Pediatric Dental Benefits Offered Through an Exchange, Whether by a Stand-alone Dental Plan or a QHP

Issuers offering QHPs in an exchange must offer at least one plan at each of the silver and gold levels of coverage, having 70% and 80% actuarial values respectively (*ACA Section 1301(a)(1)(C)(ii); 45 CFR 156.200(c)(1)*). *This certification standard should not be applied to stand-alone dental plans.*

The actuarial value of a typical children's dental plan will be in the gold or platinum level. Reducing the actuarial value of the pediatric dental benefits to the silver level would require increasing the patient cost-sharing above 50% for some benefits, making them "illusory."

Further, if a silver coverage level is required, QHP issuers may be tempted to reduce the pediatric dental benefits and provide small offsets on the medical side to meet that actuarial value. This would defeat the purpose of including meaningful pediatric dental care as an essential benefit in the ACA. This shifting of value between medical and dental benefits can be avoided if there is a separate minimum prescribed actuarial value for pediatric dental benefits. This is also another reason why QHPs should be required to separately price and offer the essential pediatric dental benefits. If medical benefits and dental benefits are priced and offered separately, the Exchange can ensure there are adequate essential pediatric dental benefits offered to Virginians. Because pricing and offer transparency is in the best interest of Virginia consumers, the Exchange should establish it as a standard for QHP certification.

United Concordia Dental recommends a minimum actuarial value of 80% (gold) for pediatric dental benefits offered through an Exchange, whether by a stand-alone dental plan or a QHP rather than applying both the silver and gold level requirements. This minimum actuarial value should be calculated on the essential pediatric dental benefits based on the projected use by pediatric-age enrollees. The use of pediatric-age enrollees as the standard population to calculate the actuarial value of a child-only benefit helps to accurately portray the value of a plan for the intended recipients of coverage. If the VHRI Advisory Council or the General Assembly believes that it needs to create an actuarial value indicator above the minimum actuarial value for stand-alone dental plans, a feasible alternative would be "high" and "low" options, with the low option being the minimum actuarial level of coverage.

Virginians with Dental Coverage Should not be Required to Purchase Duplicative Coverage

A goal of the ACA is to expand access for those not covered while allowing the continuity of coverage and care for those who have coverage today. *United Concordia recommends that when small employers bring their employees to Exchanges for medical coverage, the stand-alone dental benefits they provide for their employees outside the Exchange should be accepted if they meet Virginia's benchmark established for pediatric dental.* In addition there will be instances when children with two parents or guardians will have coverage through the parent or guardian working for a large employer. In this instance, the parent or guardian working for a small employer should not be required to purchase duplicative coverage for the children.

Requiring coverage for children's dental within the EHB, changes the dynamic of coverage. Currently, employers offer dental benefits to their employees with the election to have their families covered. Now, the policy is issued on the child with the adults as additional coverage. Therefore if the cost of the children's coverage is excessive, parents may not continue dental coverage for themselves. Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today (11 million) would drop coverage if their dental coverage is separated from their children's coverage and the cost of the children's coverage is substantial. With Pew Institute's estimate that 5.3 million children will be added to programs providing dental coverage – most in public not commercial dental plans – the net loss in coverage and reduction in access to dental care could be significant.

A considerable amount of literature exists pointing to an association between dental disease and certain medical conditions, including diabetes, heart disease, stroke, and premature or low birth weight infants. Therefore, allowing families to stay together while providing high quality dental policy options with affordable costs is critical for Virginians.

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[i] One interpretation of the Bulletin's language suggests if "pediatric oral services" is "missing" from all the selected medical benchmarks, a state should utilize the additional dental benchmarks included in the Bulletin. However, as one of the medical benchmarks, i.e. the FEHBP most common policy, includes dental coverage, another interpretation is that states would always use FEHBP and be precluded from using the two specific dental benchmarks.

[ii] NADP/DDPA White Paper: "Offering Dental Benefits in Health Exchanges: *A Roadmap for Federal and State policymakers"* September 2011 pg. 36-37, Dallas, TX.

[iii] Costs developed by Milliman for NADP as a national average. Costs will vary by geographic area. Assumptions included that no annual maximum would be applied, no deductible for class I (diagnostic & preventive) services, pediatric services provided to age 21, and national average costs.

[iv] If the standard dental deductible is not utilized and the $2,000 ACA annual deductible is coordinated with a medical plan, the cost of dental coverage could be decreased by as much as half.

[v] Actual annual limit of the MetLife FEDVIP DPPO for 2012 is $10,000. No annual maximum is used for the 2014 illustrative prices as HHS regulations indicate that annual maximums cannot be used on any of the essential benefits.

[vii] As administered today with a separate annual limit, orthodontic claims are subject to 50% coinsurance. Although the full lifetime limit is usually paid on each claim, there is significant cost sharing for the procedure. Since it is unclear whether cost sharing will be allowed for "medically necessary" orthodontic treatment, Milliman developed estimated premium for no coinsurance as well.

[viii] The range of costs for orthodontic treatment was based on the following range of alternatives derived from state CHIP programs. Lowest estimate is based on coverage for orthodontic treatment for cases of cleft palate only. The middle estimate is based approximates the application of a mid-range Salzmann index to reflect a National Center for Health Statistics study that found 29% of pediatric population had a handicapping to severe malocclusion. The high range is the provision of an orthodontic benefit as it is administered today without regard to medical necessity.

[ix] See Endnote vii

[x] See Endnote ii